FAIRFAX-
FALLS CHURCH
COMMUNITY SERVICES BOARD

INTELLECTUAL DISABILITY SERVICES

INTAKE APPLICATION

PERSONAL INFORMATION:

Applicant Name: _____
Last Suffix First Middle

If the applicant has been known by any other name(s), please list:

Alias/Maiden Name: _____
Last Suffix First Middle

Date of Birth: ____/____/_____ Is this confirmed or estimated? Actual ____ Estimate ____

Social Security Number: __ __ __-__ __-__ __ __ __ If none, please explain:_____

Driver's License Number: _____ or N/A _____

Address: _____
Street

_____
City State Zip Code County

Primary Care Physician Name: _____Phone:_____

Current Living Arrangement: _____
Code

Living Arrangement

1 Lives alone
5 Lives with relatives
6 Lives with non-related persons
9 Unknown

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Cell Phone ( ) _____ - _____

Other Phone Number (specify who):

_____

Preferred phone to contact:

☐ Home ☐ Work ☐ Cell ☐ Other

O.K. to call / leave message:

☐ Home ☐ Work ☐ Cell ☐ Other

Current Residential Arrangement _____
Code

Most Restrictive Arrangement in the last 3 months _____
Code

Residential Arrangement

0 Independent in own residence
1 Private residence/Household
2 Shelter
3 Boarding house
4 Foster home
5 ACR residential
6 Community residential program
7 Other residential setting
8 Nursing home
9 Hospital
10 Local jail or correctional facility
11 State correctional facility
15 Residential treatment facility
20 Other institutional facility
30 None (Homeless, not sheltered)
40 ACR regular assisted living
41 ACR intensive assisted living
51 Western State
60 NVTC
61 CVTC
96 For PEI clients only
98 Unknown

Gender: _____

Marital Status: _____
Code

Marital Status
3 Never married
4 Married
5 Married legally separated
6 Divorced
7 Widowed
8 Married living apart
9 Unknown

Race: _____
Code

Race
1 White/Caucasian
2 Black/African American
4 Asian/Pacific Islander
5 Alaskan Native
6 American Indian
1 Multiracial
2 Decline to answer
U Unknown
9 Other

Hispanic Origin: _____
Code

Hispanic Origin
1 Cuban
2 Mexican
3 Puerto Rican
5 Hispanic – specific origin unknown
6 Other Hispanic
7 Not Hispanic
8 Declined to answer
9 Unknown

US Citizenship: □ Yes □ No

Veteran Status: □ Yes □ No □ Unknown

Days of Paid Work in Past 30 Days ___

Employment Status: _____
Code

Employment Status
1 Employed full time (35+/wk)
2 Employed part time (< 35/wk)
N Unemployed - seeking
3 Not in labor force –homemaker
4 Not in labor force – student
5 Not in labor force – retired
6 Not in labor force – disabled
7 Not in labor force – institution
8 Not in labor force – child
9 Not in labor force – other (not seeking)
P Employment Program
U Unknown

Special Education: □ Yes □ No

If yes, date of graduation:____/____/_____

Education Level _____
Code

Education Level
1 Never attended school
3 Preschool/Kindergarten
4 Grade 1-7
5 Completed 8th Grade
10 Some HS or vocational education
15 Completed HS or vocational education
20 Some college (<4 years)
30 Completed college (4 + yrs)
98 Unknown

Referral Source: _____
Code

Referral Source
1 Self
2 Family or friend
5 Employer/EAP
10 School system/Educational agency
11 Police/Sheriff
12 Court - Other
13 Juvenile & Domestic Court
14 General District Court
17 DRS
25 Local correctional facility
26 CDI
27 ASAP/DUI
28 State correctional facility
29 Private MH OP provider
31 State MH Outpatient Provider
32 CSB MH Program
33 Infant/toddler connection
34 CSB ID Program
36 CSB AD Program
37 State MH facility
38 State ID facility other
39 ID care provider
40 Private hospital
41 Private physician
42 OT/PT/Speech Therapist
44 Non hospital SA care provider
50 State institution NVTC
51 State institution CVTC
60 Managed care org. (HMO)
65 County Unified Intake
75 Probation
76 Parole
81 Health Department
87 Housing and Community Dev.
88 DHD/DSS APS
89 DHD/DSS CPS
90 DHD/DSS Foster Care
91 DHD/DSS other (not TANF)
92 DHD/DSS - TANF CW
95 Other VA CSB
98 Unknown
99 Other community referral

Physical Disability (Check all that apply):

- □ Deafness or severe hearing loss
- □ Inability to communicate verbally
- □ Seizure Disorder
- □ Declined to answer
- □ Blindness or severe visual impairment
- □ Traumatic head injury
- □ Cerebral Palsy
- □ Unknown
- □ Non/Difficulty in ambulation
- □ Major medical/chronic health problems
- □ None
- □ Other

Primary Language _____
Code

Primary Language

1	English
2	Spanish
3	French
4	German
5	Indochinese
6	Farsi
7	Gestures
8	American Sign
9	Other language

LEGAL/COURT/GUARDIANSHIP:

Please describe any criminal history or legal/court involvement:_____

_____

_____

_____

Type of Guardianship:
□ Full/Conservator □ Partial Guardian □ Partial Conservator □ None

If other than none, please indicate the Guardianship Status (select one):

- □ For minor: parents
- □ For minors: CPS
- □ For minor: emancipated
- □ For minor: court
- □ For minor: other
- □ Guardianship recommended .
- □Court is legal guardian/conservator
- □ For adult: own guardian
- □ For adult: guardian of estate
- □ For adult: guardian of person
- □ For adult: guardian of estate/person
- □ For adult: limited guardian
- □ Power of attorney
- □ For adult: other

Date Guardianship Awarded ____/____/_____

Relationship of (Primary) Guardian (select one):

- □ Siblings
- □ Father
- □ Mother
- □ Spouse
- □ Child
- □ Other relative
- □ Other non-relative
- □ Parents / Stepparents
- □ Other
- □ Self

RELATIONSHIPS:

For the following relationships table, please indicate significant others of the applicant, including parents and/or any other primary caregivers, emergency contacts, guardians, and representative payees for benefits. For each individual, fill in the name, relationship to the applicant, address and phone numbers (if different than applicant), date of birth, and whether or not they are a primary caregiver, emergency contact, guardian and/or benefits payee. **For primary caregivers, please indicate their health status using one of the following descriptors: Life threatening, poor, fair, good, or excellent.**

RELATIONSHIPS

Name & Relationship	Address & Phone Numbers	Date of Birth	Primary Caregiver?	Emergency Contact?	Guardian?	Benefits Payee?
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No

FINANCIAL/INSURANCE:

Applicant's Gross Annual Income $_____

Number of Dependents:_____

Insurance Company Name:_____

Policy Number:_____

Printed Name of Person Completing the Application	Relationship to Applicant	Telephone

Signature of Person Completing the Application	Date

In order to expedite the intake process, please gather and attach the following documentation to this intake application:

1. Reports of psychological evaluations and/or developmental evaluations
2. School records, such as a Social History, Individualized Education Plan, Basis for Committee Decision
3. Other professionals' supporting documentation of disability

Please mail this completed application and all supporting documentation to the following address:

Intellectual Disability Services
Attn: Intake Support Coordinator
12011 Government Center Parkway
Suite 300
Fairfax, Virginia 22035

Upon receipt of the intake application, an Intake Support Coordinator will contact you to answer any questions you may have, and to coordinate obtaining any further documentation needed. If you do not hear from our agency within two weeks, please call 703-324-4400 and request to speak with an Intake Support Coordinator.